Unearthing the Buried City

The Janet Translation Project

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This document is part of *Unearthing the Buried City: The Janet Translation Project*, a series of AI-assisted English translations of Pierre Janet's works.

In his seminal 1970 book: *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, Henri Ellenberger wrote:

> *Thus, Janet's work can be compared to a vast city buried beneath ashes, like Pompeii. The fate of any buried city is uncertain. It may remain buried forever. It may remain concealed while being plundered by marauders. But it may also perhaps be unearthed some day and brought back to life* (p. 409).

This project takes Ellenberger's metaphor seriously — and literally. The goal of this work is to unearth the buried city of Janet's writings and make them accessible to the English-speaking world, where much of his legacy remains obscured or misunderstood.

Pierre Janet was a pioneer of dynamic psychology, psychopathology, hypnosis, and dissociation. His influence on Freud, Jung, and the broader psychotherapeutic tradition is profound, yet the bulk of his original writings remain untranslated or scattered in partial form. These AI-assisted translations aim to fill that gap — provisionally — by making Janet's works readable and searchable in English for the first time.

This is not an academic translation, nor does it claim to replace one. It is a faithful, literal rendering produced with the aid of AI language tools such as Chat GPT and DeepL and lightly edited for clarity. Its purpose is preservation, accessibility, and revival. By bringing these texts to light, I hope to:

- Preserve Janet's contributions in a readable English form
- Spark renewed interest among scholars, clinicians, and students
- Inspire human translators to produce definitive, academically rigorous editions

Some Recent Definitions of Hysteria[1]

By Mr. Pierre Janet

The definitions of hysteria were formerly very numerous, and every author was obliged to review around fifty formulations presented by his predecessors before expressing in turn his own thought.[2] But when a more precise study revealed the variety of these phenomena — more numerous "than the forms of Proteus and the colors of the chameleon" — one no longer dared to group them under a single formula. While Lasègue who nevertheless remain convinced of the existence of rigorous laws in hysterical manifestations do not attempt to define this malady. "*We provisionally designate*," he says, "*under the name hysteria, a set of nervous manifestations occurring preferably in young women, recognizing that young men are affected only in rare exceptions, and not revealing any known lesion of the nervous centers*."[3] He does not shy away from mentioning a singularly contestable value of this definition; for he later declares that "the definition of hysteria has never been given and never will be. The symptoms are not constant enough, not conforming enough, nor equal enough in duration and intensity for even a descriptive type to be able to comprehend them all."[4] He prefers to limit himself "to studying each of the symptomatic groups in isolation; after this preliminary work, the fragments will be assembled and the whole of the illness will be reconstructed."[5]

The advice given by Lasègue was followed and the most competent authors avoided pronouncing on the general definition of this illness. Most limited themselves to pointing out a certain number of characteristics that allow one to recognize the hysterical nature of a phenomenon. M. Babinski, for example, shows that one can make a diagnosis by studying:

(1) *the symptomatic aspect*;
(2) *the evolution*;
(3) *the etiology*;
(4) *the influence that this or that treatment may have*;
(5) *the information provided by experimentation under hypnosis*.[6]

Quite recently, M. Pitres, at the beginning of his lectures, showed the shortcomings of various definitions and refused to give another; he limited himself to enumerating certain common features that allow one to recognize "the nosological specialty of the accidents..." These features, he says, are not

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[1] Janet, Pierre. "Quelques définitions récentes de l'hystérie," *Archives de Neurologie*, xxv (June, 1893), pp. 417-438; xxvi (July, 1893), pp.1-29.
[2] See the long preface—interesting, moreover—by Brachet, *Traité de l'hystérie*, 1847, and its chapter on Definitions, p. 202.
[3] Lasègue. — *Catalepsies partielles*, 1865. (*Études médicales*, t. I, p. 898.)
[4] Lasègue. — *Hystéries périphériques*, 1878. (*Études médicales*, t. II, p. 78.)
[5] Lasègue. — *De l'anorexie hystérique*, 1873. (*Études médicales*, t. II, p. 45.)
[6] Babinski. — *De la migraine ophtalmique hystérique*. (*Archives de Neurologie*, 1891. Extrait p. 8.)

numerous; in any case, they can be summarized in the following five propositions:

(1) *Hysterical accidents are the consequence of purely functional disorders of the nervous system*;

(2) *they can be suddenly provoked, modified, or suppressed by psychic influences or by physical causes which have no effect on similar accidents dependent on organic lesions*;

(3) *they are very rarely isolated; in the vast majority of cases, certain latent stigmata coexist with the striking manifestations of neurosis*;

(4) *they have no regular evolution; they appear without warning and follow one another in different forms and at different times in the same subjects*;

(5) *they have usually little effect on the general health and the mental state of the subjects who are affected does not show the profound deterioration that similar accidents due to another cause would produce*.[7]

These various features are just as interesting as they are useful in helping to judge the scope of the idea of hysteria. M. Gilles de la Tourette, in a very important work,[8] brought together the richest collection of documents relating to hysteria, considered it more scientific not to provide, at least in this first volume, a general definition of the illness.

This resolution to abstain from a general definition has undoubtedly had useful results; it has allowed observers to concentrate their attention on isolated observations without taking contradictions into account, without worrying about theories; it has allowed the collection of the enormous number of valuable documents we now possess. But it is easy to see that it has not been without drawbacks. A very vague idea of the illness to which the characteristic is attached has emerged from an idea of an isolated characteristic; there is no longer much agreement among the different authors who nevertheless believe they are speaking about the same issue. No doubt, students of the same school who have the same habits of examination and language more or less agree on the diagnosis of hysteria, but authors who have received a different education do not always refer to the same disorders. It is impossible to deny that many of the discussions on sensory disorders, on suggestions, on somnambulism, were born from this confusion, and it is clearly desirable that each author clearly state what he understands by a hysterical subject so that his observations can be verified.

Perhaps, when it is declared that the definition of hysteria is impossible, too ambitious an idea of definition has been formed. We are obviously incapable in this case, as in all others, of knowing the true nature, the essence of a thing, nor the ultimate explanation of any phenomenon. But a definition, even in purely rational sciences like mathematics, has never provided this essence, this explanation. Our definitions are only general ideas, summaries that must merely include the greatest number of possible facts. A perfect definition would be one that encompassed in a single formula absolutely all the facts that one can observe about a given object. It is unrealizable, since we do not know all these facts. A definition would be excellent if it summarized only all known facts, but even that

[7] Pitres. — *Leçons cliniques sur l'hystérie*, 1891, t. I, p. 4.
[8] Gilles de la Tourette. — *Traité clinique et thérapeutique de l'hystérie*, 1891.

is still an ideal that is difficult to attain. A definition is sufficient when it expresses in a single phrase the majority of known facts. Without a doubt, such a formula, like any scientific theory, is provisional since the known facts increase unceasingly and soon render it too narrow. But one does not invalidate such a definition simply by showing that this or that detail is not included in it; to render it useless, one must oppose to it another simpler and more general definition encompassing not only the facts included in the first but others as well. If one holds to this modest conception of definition, is one entitled to say that a sufficient definition of hysteria is today impossible? Is there not any common characteristic that links the majority of facts gathered from both sides? If there were not, hysteria would not exist and would not deserve to be studied as a distinct illness.

This is what some contemporary authors have thought; they believed that the time had come to pause a bit in the enumeration of facts and to summarize the acquired knowledge as much as possible. Once again, various definitions of hysteria are being proposed. These attempts do not seem to us entirely blameworthy, and we believe it is useful to summarize the works that have recently been published on this subject by Messrs. Möbius,[9] Oppenheim,[10] Strümpell,[11] Jolly,[12] Donkin,[13] Laurent,[14] A. Pick,[15] Breuer and Freud.[16] This general review does not claim to be complete—no doubt many works have remained unknown to us. Moreover, to give some unity to this study, we will especially consider the authors who have examined the mental, psychological aspect of hysteria. It is simply a group of definitions that we wish to present: they have some common features and were presented simultaneously from various perspectives, which seems to us to give them, at least from a historical point of view, a certain interest. Since some of these studies refer to our own work and even adopt the general ideas we previously expressed about the nature of hysteria, we ask permission to summarize them in a few words; perhaps, by bringing together these various studies, we may express a provisional definition that can summarize a fairly large number of known facts.

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[9] Möbius. — *Ueber den Begriff der Hysterie* (aus dem *Centralblatt für Nervenheilkunde*, von d. Erlenmayer, XI, 1888, no. 3).

[10] H. Oppenheim. — *Aus der Nervenklinik der Charité. Thatsächliches und Hypothetisches über das Wesen der Hysterie*, October 1889.

[11] A. Strümpell. — *Ueber die Entstehung und die Heilung von Krankheiten durch Vorstellungen.* Rede beim Antritt des Protectorats der Kgl. Universität Erlangen, November 1, 1892.

[12] F. Jolly. — *Ueber Hysterie bei Kindern.* (Sonderabdruck aus der *Berliner klinischer Wochenschrift*, 1892, no. 34.)

[13] Donkin. — Article *Hysteria*, dans le *Dictionary of Psychological Medicine* de Hack Tuke, 1892.

[14] L. Laurent. — *Des états seconds, variations pathologiques du champ de la conscience*, 1892.

[15] A. Pick. — *Ueber die sogenannte "conscience musculaire" (Duchenne).* (*Zeitschrift für psych. und physiol. der Sinnesorgane*, herausgegeben von H. Ebbinghaus und A. König, t. IV, 1892).

[16] J. Breuer & S. Freud in Vien. — *Ueber den psychischen Mechanismus hysterischer Phänomene.* (Aus *Neurologischen Centralblatt*, E. Mendel, 1893, nos. 1 et 2.)

I. Hysteria, Illness by Representation

A definition, as we know, can only summarize facts by grouping them around a "dominant" phenomenon—that is, by highlighting a principal and clearly defined characteristic that is, by hypothesis, the most important, and from which it is assumed, as clearly as possible, that all other facts depend. In old definitions, the chosen characteristic was most often a physical one—either an injury, or a supposed modification of basic physiological phenomena. For a long time, the movements of the uterus through the body, its alterations, its pains, were the center around which all other symptoms revolved. These definitions included only a small number of phenomena, and that is the criticism we now level at them. Later, another phenomenon, also considered at the time to be uniquely physical—the seizure—became predominant, and hysteria was essentially viewed as a convulsive illness. *"Hysteria,"* said Brachet, *"is a neurosis of the cerebral nervous system, which most often manifests in sudden seizures of generalized clonic convulsions and the sensation of a globe ascending in the esophagus, from the upper extremity of which arises a fixed fear of causing a threat of suffocation.*"[17] These definitions were a bit more comprehensive than the previous ones, as the phenomena related to the seizure were certainly more numerous than those dependent on uterine modifications. But they exhibited a major gap: they left aside nearly entirely the interparoxysmal characteristics and incidents, which are numerous. Since a large number of authors had failed to group the symptoms around a physical phenomenon, there was a shift in perspective: people began looking among cerebral, psychic phenomena—long observed in this illness—for a more important symptom capable of coordinating a large number of facts. The definitions of hysteria evolved and became psychological.

The book by Briquet, 1859, is very important from this point of view; it thus constitutes, so to speak, an intermediary between purely physical conceptions and moral interpretations of hysteria. *"Hysteria,"* he says, _"*is a neurosis of the brain whose apparent phenomena consist mainly in the disturbance of vital acts that serve for the manifestation of affective sensations and passions*."[18] Hysteria thus becomes an emotional illness and can doubtless more easily be connected to a very large number of symptoms as emotional phenomena. Unfortunately, emotion is rather poorly analyzed by Briquet, and the explanation of the main symptoms remains quite vague. One point in particular, among many others, remained troubling: emotion is an apparently accidental and momentary phenomenon—how can one connect to it permanent phenomena that last for months or years? And how can one suppose the persistence of emotion when the patient seems entirely calm and indifferent? Nevertheless, Briquet's study can be considered the starting point for psychological research on hysterics.

This study only began in a precise manner with the work of Professor Charcot, at the Salpêtrière, on the traumatic accidents of hysterical patients. Revisiting in

[17] Brachet. — *Traité de l'hystérie*, 1847, p. 204.
[18] Briquet. — *Traité clinique et thérapeutique de l'hystérie*, 1859, p. 3.

order to complete and explain the earlier works of Brodie[19] and Reynolds[20], M. Charcot demonstrated that certain severe movement disorders could not be explained by any clear and defined lesion of the nerve centers. In his lectures from 1884–1885, he explained how, through meticulous analysis, one could diagnose the difference between an organic paralysis and a properly hysterical paralysis.[21] The case histories, the absence of fever, the trophic disorders and the degeneration reaction, the preservation of tendon reflexes, the distribution of anesthesia, etc., made it possible to eliminate, one by one, all suppositions relating to material lesions of the nerves, spinal cord, or brain. These diagnostic studies were and still are of major importance—it is quite evident that it would be absurd to interpret a paralysis psychologically without first having demonstrated, through prior analysis, the insufficiency of more banal explanations.

Having thus established his clinical starting point, M. Charcot was able to show, by studying the origin of the incident, its characteristics, its evolution and its cure, that it involved moral phenomena—that is to say, of course, psycho-physiological phenomena. Finally, he confirmed this explanation by introducing the procedures of suggestion as a scientific method for diagnosing and analyzing nervous diseases. He showed that this paralysis could be reproduced by suggestion either in the patient himself, or in other hysterics: verbal affirmation, or a simple gesture that evoked in the subject's mind an idea or a similar emotion, produced paralyses completely identical in their characteristics to natural accidents.[22] *"In certain circumstances,"* he said, *"a paralysis may be produced by an idea…*[23] *Due to the immobilization thus brought about in us by hypnotism, or in the other case, as has been imagined, by being electrocuted, this idea, once established, made strong in the mind and reigning there without control, would develop and acquire enough force to manifest objectively in the form of paralyses..."*[24]

Later, M. Charcot applied the same reflections to contractures,[25] to more or less intense hyperesthesias,[26] and even to hysterical incidents that seemed entirely different—to vomiting, to anorexias,[27] to mutisms.[28] Everywhere, he demonstrated the importance of the *fixed idea* that produced and sustained the incident, the reproduction of identical facts through suggestion, treatment by isolation, and the moral influences that modified not the physical state but the pathological mental state of the hysteric.

This conception of illnesses through suggestion was far from being accepted at that time, just as it still encounters much resistance today. M. Georges Guinon

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[19] B. Brodie. — *Lectures illustrating of certain local nervous affections.* London, 1837.
[20] Reynolds. — *Remarks on Paralysis and Other Disorders of Motion and Sensation Dependant on Idea*, 1869.
[21] Charcot. — *Maladies du système nerveux*, t. III, p. 288 and following.
[22] Charcot. — *Maladies du système nerveux*, t. III, p. 354.
[23] Id., *ibid.*, t. III, p. 335.
[24] Id., *ibid.*, t. III, p. 355
[25] Charcot, *ibid.*, t. III, p. 375, 394.
[26] Id., *ibid.*, t. III, p. 453.
[27] Id., *ibid.*, t. III, p. 241.
[28] Id., *ibid.*, t. III, p. 506.

summarized the history of these discussions,[29] and showed us how this doctrine eventually triumphed. The psychophysiological mechanism by which the accident is realized remains obscure and debatable, but there is no longer any serious author who completely denies the existence of hysterical accidents through imitation, suggestion, or idea. In his work on the provoking agents of hysteria, M. Guinon also shows that, in certain cases, one can observe the *fixed idea* which determines the hysterical accident. The patient dreams of their accident, thinks about it constantly, and this obsessive thought can be interpreted as: "I no longer feel my hand, I can't move my arm, my arm is heavy,"[30] etc. These ideas take on great importance and determine not only hysterical illness in general, but even more so the particular form the accident takes. At the same time, M. Dutil demonstrated in several observations the importance of fixed ideas and traumatic dreams in the formation of hysterical accidents.[31] Whatever the mechanism by which these ideas lead to motor tics, chorea, or contracture, it is the constant repetition—the persistence of the idea—that is properly hysterical and characterizes the illness.

M. Charcot always expressed these theories with great moderation, limiting their role to explaining a few specifically determined clinical cases. What remained was to generalize this conception a bit more and apply it to the entire hysterical condition—this was, we believe, the role of M. Möbius. This author pays tribute in the most courteous way to the work of M. Charcot; he, I believe, complements it with an interesting idea. *"A prevailing opinion,"* he says, *"is increasingly being established: it is that hysteria is a psychosis and that the modification that characterizes it is a morbid state of the mind."*[32] But these mental modifications do not only manifest through delusions and character changes; they are especially manifested by incidents of physical appearance. These are involuntary movements, spasms, paralyses, as well as crying, laughter, vomiting, etc. And it seems that, in all forms of madness, bizarre movements are also the consequence of false ideas. In M. Möbius' view, the movements of the insane person are only indirectly related to their delusion; it is the patient themselves who stirs and moves, obeying an imaginary order. In hysteria, the relationship is more immediate: thought transforms into movement without the subject's will being involved. This feature is characteristic and has served M. Möbius to formulate the central definition of the illness: *"We may consider,"* he says, *"that all bodily modifications in hysterics are caused by representations."*[33]

M. Strümpell's speech expresses similar ideas: "*What is called nervousness is, from a scientific point of view, above all a spiritual and not a bodily disposition… certain representations that are too strong, certain associations of ideas that are too easy become the starting point for a great series of accidents with bodily appearance*."[34] M. Strümpell agrees with previous authors in explaining these

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[29] Georges Guinon. — *Les agents provocateurs de l'hystérie*, 1889, p. 42.
[30] Id., *ibid.*, p. 360.
[31] Dutill. — *Hystérie et neurasthénie associées*, (*Gazette médicale de Paris*, 1889. Extrait no 10.)
[32] Möbius, *op. cit.*, p. 1.
[33] Möbius, *op. cit.*, p. 2.
[34] Strümpell, *op. cit.*, p. 8.

neuropathic accidents through representations (*durch Vorstellungen*). To the purely physical definitions of hysteria is thus added a new definition that seeks to group the symptoms around a moral phenomenon. "*Hysteria is a collection of illnesses by representation*."

II. The Doubling of the Personality

A large number of hysterical incidents seem to depend on certain fixed ideas, on certain suggestions; but can one, as M. Möbius attempted, extend this explanation to all incidents and transform it into a definition of hysteria? This is what has seemed highly questionable to several authors, and what was rightly criticized by M. Oppenheim, and then by M. Jolly.[35] Let us try to clarify these somewhat vague criticisms by following the method we have proposed for examining definitions.

(1) A large number of hysterical accidents, clearly localized like the preceding ones—hyperesthesias, tics, paralyses, spasms—seem to bear no relation to any idea, any imagination of the subject. The patient, no matter how one questions them, and despite their good will, affirms that they are not thinking about moving their arm, squeezing their hand, making a grimace; better yet, they have no idea of the spasm, they do not even feel it, they observe their own accidents without knowing how they occur.[36] There are, in fact, two categories of hysterical accidents that can be easily distinguished by examining tics or spasms.
Some occur *when the subject thinks about it*, and disappear when the subject is distracted or falls asleep—these can easily be connected to an idea.
But the others occur *even when the subject is not thinking about it*; the spasm persists despite distraction, sometimes even despite sleep. These are not, at least in appearance, accidents that depend on a mental representation. At the beginning, perhaps, the subject was aware of an emotion, of an idea more or less vague, but it is evident that these phenomena of consciousness have been erased and that, currently, they no longer exist.

(2) The hysteric does not present only permanent accidents of this kind; she presents a much more frequent and much better-known phenomenon: the attack. Now, this attack is not a simple act like the contraction of the hand—it is a very complex ensemble of convulsions, cries, speech. The subject does not have in mind the representation of this whole series of phenomena; they are unaware of them, since, in the majority of cases, they awaken from the attack without knowing what has just occurred. These attacks, which reproduce with monotonous regularity, seem to depend on some physical phenomenon, for they are independent of the subject's thought, and it is sometimes enough to provoke them not by awakening ideas, but by pressing a point on the body—the ovary or the epigastrium—for the discharge to occur.

(3) Let us consider more precisely moral accidents, delusions, somnambulisms, which unquestionably belong to hysteria; we are no more in the presence of a fixed, clear, and simple idea. The subject does not know what is happening during their

[35] H. Oppenheim, *op. cit.*, p. 3. — Jolly, *op. cit.*, p. 12.
[36] Breuer & Freud, *op. cit*., p. 1.

somnambulism or their delirium and is not thinking about it. When the accident occurs, it is composed of a long sequence of sensations and very varied thoughts that had not at all been foreseen by the patient.

In a word, even setting aside the stigmata, considering only the accidents, it is impossible to relate them all to bodily modifications produced by conscious representations.

Let us therefore try to change our point of view and to take another phenomenon as the center of the definition. These are again the studies of M. Charcot and his students which have shown how much *somnambulism* played a major role in hysteria. This phenomenon first appears spontaneously in these patients under many different circumstances. Sometimes it exists in the form of nocturnal somnambulism, sometimes it develops in full daylight in the form of an attack preceded or not by convulsions. At times, it grows in a remarkable way—to the point of occupying whole days or even entire months; it begins at periods of secondary existence, of which M. Azam showed one of the first and most curious examples, and which have since been so frequently observed.[37] Finally, somnambulism can be provoked, if not in all, at least in most hysterical patients, and these artificial states can present all the features and all the varieties that have been observed in natural somnambulisms.[38]

It is not easy to grasp the essential phenomenon that characterizes somnambulisms; as these states are extremely numerous and varied, one observes in them physical and moral modifications that are not found in the other states. We have tried to show elsewhere[39] that "the somnambulistic state does not present characteristics that are proper to it, that are in some way specific to it... It only has relative characteristics and can only be determined in relation to another moment in the subject's life, to the normal state or the waking state." The forgetting of everything that happened during the somnambulism when the subject returns to the normal state, despite all the complications that this symptom may present, seemed to us the only constant and essential character of somnambulism. Most often, the lost memories reappear when the subject once again enters the abnormal state, and this amnesia, followed by a periodic return of the memories, establishes a kind of split between the two states. An individual who is truly somnambulistic in two distinct ways experiences "two psychological existences alternating successively"; they have in one state sensations, memories, movements that they do not have in the other, and consequently, they present in the clearest cases two distinct sets of traits and, in a way, two personalities. Somnambulism in its most complete form must therefore be considered as identical to these great phenomena of double existence which have been so often described under different names; and the result is that these different designations are equivalent.

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[37] See a summary of these observations in the thesis of Mr. Laurent, *op. cit.*, p. 13.

[38] *Les actes inconscients et la mémoire pendant le somnambulisme*. *Revue philosophique*, 1888, t. I, p. 258, and *Automatisme psychologique*, 1889, 73, p. 125.

[39] *Psychological Automatism*, 1889, p. 448.

This state is provoked in various ways: sometimes, the first personality—the first grouping of psychological phenomena—disappears through sleep, through fatigue of attention, and the second group develops easily. In other cases, a sort of periodic alternation is established by habit, and the second system reproduces regularly when the first has lasted for a certain time. More often still, in our opinion, some minor event, a particular sensation for example, is found to be associated with the group of phenomena that constitutes somnambulism, and when this sensation is provoked, it automatically brings with it the entire system of which it is a part. That is why such-and-such a signal will suffice to bring about the somnambulism of such-and-such a patient: one will quickly enter into this state because I touch her forehead, a second because I press her thumb, a third because I show her my finger. These signals are all-powerful not to create the doubling and form the second personality, but to evoke it when it already exists.[40]

If one understands somnambulism in this way, it is easy to note that a large number of hysterical accidents can be connected to it. Not only the long periods of double existence, but also very short-duration states during which the patient seems to walk or act automatically, those fugue states of which he is unaware when he seems to awaken, those interminable reveries from which one can hardly rouse him and which he cannot explain,[41] these ecstasies, these more or less complete catalepsies, etc.—are nothing but degrees or varied forms of somnambulism, of reappearances more or less complete of the second existence. Certain delusions even, in which the subject screams, insults, seems to play a role, also appear to us to be somnambulisms modified by particular influences.

But one can go much further, and M. Charcot long ago established a notion that we consider essential for the interpretation of hysteria: it is the close relationships that exist between the somnambulistic state and the properly so-called hysterical attack. M. Charcot showed that on the one hand, the attack very often contains phenomena of a somnambulistic nature, and on the other hand, that natural or provoked somnambulisms are often preceded or even accompanied by a great number of symptoms belonging to the attack. The subject would continue in the following attack the acts or dreams begun in the preceding one; he would have in the somnambulism the same strangulations, the same contractions as in the attack—finally, the procedures that ended or modified one would also succeed in ending or modifying the other.[42] We believe we have added a few notions to this study done at the Salpêtrière. The subjects, we said, pass very easily from one state to the other, from the crisis to somnambulism or reciprocally.[43] Memory, which is so important, presents in both of these states an essential characteristic—it is reciprocal: the patient during the attack remembers the somnambulism, and it

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[40] *Autom. psycho.*, p. 455.

[41] Reveries and ecstasies seem to us more frequent and more important in hysteria than is generally believed; they form special attacks which will be studied in greater detail in our work on *Les accidents mentaux de l'hystérie*.

[42] Charcot. — *Mal. du syst. nerveux*, t. I, p. 447. — Paul Richer, *La grande hystérie*, 1885, p. 301. — Pitres, *Leçons cliniques sur l'hystérie*, 1891, t. II, p. 235.

[43] *Autom. psych.*, p. 52.

is not until the somnambulism that he clearly recalls the memories of the attack.[44] These are two states whose general features are entirely comparable.

This comparison between the attack and somnambulism can be pursued even into the details. Let us consider, in fact, the beginning of the attack or the procedures that succeed in provoking it. The attack is sometimes spontaneous—at least in appearance—especially when it occurs regularly after a certain period of normal life, just as is often the case for somnambulisms. But more often, the attack is provoked by a psychological phenomenon that is associated with the emotional state, the fixed idea, the dream constituting the second existence. A hysterical woman who in her attacks is in profound despair over the death of her child, or in terror caused by a fire, has only to think of her child or even of some object, has only to look at a small flame or simply a piece of red paper to have an attack. These provocative sensations which play the role of a signal can be determined in some cases by the touching of a point on the body. A child running in the street chased by a drunkard stumbles and falls forward on his stomach. Ever since, it is enough to touch his stomach for him to have a terror attack in which he sees the drunkard throw himself at him, tries to escape, and cries for help. A point on the body that was painful at the moment of an emotion, or to which the subject's attention was drawn accidentally or even through medical examination, will henceforth be associated with the attack and become its signal. "We used to say," we said previously, "that pressing hysterogenic points—that is, provoking a specific sensation belonging to the group of psychological phenomena of the crisis—brings on the convulsive attack, just as calling by name some of the subjects who have been described in somnambulism, with the name given to them during the somnambulism, is enough to bring about the complete somnambulistic state."[45] One could make the same remarks about the phenomena that characterize the end of the attack or the end of somnambulism.

Let us move on to the study of the very development of the attack: what has struck all observers is the absolute regularity, almost mathematical, of the attacks in the same patient. It is always the same gestures, the same movements, the same cries, the same words: one can predict minute by minute what is going to happen. Much has been discussed to know whether there is a general type of hysterical attack, but it is undeniably established that there is an individual type and that each patient preserves their own for years. It is exactly the same with natural somnambulisms: one carries a pillow in their arms as if it were a child and always walks the same path on the rooftops, another always prepares a poisoning by putting matches into a glass. That the somnambulism is repeated ten or a hundred times, it is always the same acts in the same subjects. Finally, one finds the same character in artificial somnambulisms: the subject has the same attitudes, the same words, they obey the same signs, change states depending on whether they are touched here or there. If the operator makes a mistake, the subject never deceives themselves and only functions truly when not regularly directed, when one does not observe with meticulous care all the procedures to which they are accustomed.

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[44] *Actes inconscients et dédoublement de la personnalité*. (*Revue philosophique*, 1886, t. II, 590.) — *Autom. psych.*, p. 87, 120, 448.

[45] *Automatisme psych.*, 1889, p. 456. — Same remark, Breuer & Freud, *op. cit.*, 1893, t. II.

The automatic regularity also characterizes all these states and is, in our view, easily explained. The second existence is truly a psychological existence in which sensations and ideas always reappear in the same forms, do not mix, and do not modify one another. The fixed ideas which we have seen play such a large role during the waking life of hysterics are here even more powerful and develop with greater regularity.

Let us now examine the content of the attacks—the acts and the words that fill them. Some attacks are so simple that they are clearly nothing more than the meticulous reproduction of an event from the subject's life, entirely identical to most spontaneous somnambulisms. Others do not seem to be of this nature: they are simply convulsions, cries, respiratory efforts without clear meaning. It seems to us that these should be regarded more as attitudes and contortions—as manifestations of ideas, emotional expressions. We are far from knowing exactly what all the movements of the limbs, the contortions of the face, the circulatory and respiratory disturbances that accompany or better said, constitute each emotion, mean. We only know that emotion is nothing but a system of phenomena of this kind. We also do not know by what mechanism all these manifestations intensify and are repeated when the emotion is very violent, very repeated, when it develops automatically without being moderated by the conscious perception of other phenomena. We therefore cannot explain by the laws of emotion every attitude and every gesture of the subject, but we can suppose—from the signs that a vulgar hysterical attack gives off—that it is the automatic reproduction of an emotional state. One can observe this by examining the subject's ideas and feelings that regularly occupy their mind before the attack or somnambulism and fill their thoughts during the crisis. Putting the subject in somnambulism, and making use of the memory they have at that moment only of emotions experienced during the attack, one observes that a single emotion—anger, fear, despair—repeats itself regularly in each of these crises.[46] Most likely, these repeated hysterical crises are of the same nature: they consist in the automatic reproduction of a single intense emotion, with its gestures, cries, breathing, and attitudes.

These studies on attacks and somnambulisms seemed to bring together and unite an important category of hysterical symptoms—the periodic accidents—but appeared to leave aside the permanent accidents, those motor disturbances so well summarized elsewhere by the theories of M. Charcot and M. Möbius. Is this separation of these two groups of facts so absolute? That is not what we believed; we sought their unity by studying the manifestations of the second personality in the interval between somnambulisms and attacks.

This investigation was begun through the study of post-hypnotic suggestions. In certain cases, these suggestions can only be executed correctly thanks to certain calculations and certain reflections. A subject was told to perform an action in eight days; it is clear that, upon waking, he must remember the command and count the days separating him from the moment of execution. Yet he seems, upon waking, to have no memory of the suggestion and to be unaware of any

[46] *Actes inconscients et dédoublement de la personnalité*. (*Revue philosophique*, 1886, t. II, p. 590.) — Same remark, Jolly, *op. cit.*, 1892, p. 5, and Breuer & Freud, *op. cit.*, 1893, p. 9.

calculation or reflection.[47] We were led in these cases, and in many others like them, to admit that a certain intelligence persists in the subject's mind without his knowledge, outside of and thereby apart from his consciousness and his personality. Acts of this kind are very numerous; one easily observes that the subject is distracted and yet is made to perform fairly complex acts without knowing it; they are also observed when studying the complex and intelligent movements that one can produce in anesthetized limbs. There is a very characteristic phenomenon where such actions manifest in an absolutely clear manner: it is the spontaneous unconscious acts and the automatic writing of mediums.[48] These writings are not only involuntary, they are still, in most cases, entirely unconscious—that is to say, completely unknown to the normal personality of the medium; but they show such intelligence that they demonstrate the existence of a second consciousness, distinct from the real self. Finally, in some experiments studied especially by English authors—and whose accuracy we have been able to verify—one can provoke in the subject not just movements, but visual hallucinations that also originate in subconscious thoughts.[49] The subject, by gazing at a piece of crystal, sees images there—letters corresponding to ideas, to memories that he sincerely believed he did not possess and that suddenly appear to him as supernatural revelations.

This second thought, existing beneath and outside of the first, is not a new phenomenon to us. It is easy to demonstrate that it is closely linked with the second existence that characterizes somnambulism. One observes during somnambulism the memory of all these so-called unconscious acts—these very acts and particularly automatic writing clearly reveal the full memory of the somnambulism, and the transition from one set of phenomena to the other is extremely easy and frequent. One could summarize the facts by saying: "these acts seemingly subconscious are not something separate from somnambulism; they are somnambulism itself but no longer isolated, alternating with waking, but instead extending into waking without interruption."[50] Of course, we are not speaking here about variations or fine distinctions like "types of somnambulism each bringing with it the memory of a particular set of subconscious acts."[51] We must recognize that this "subconsciousness," as the well-known M. Ch. Richet called it,[52] is of the very same nature as somnambulism itself; it results like somnambulism from a splitting of personality. All psychological phenomena that occur in the brain are not gathered into a single personal perception—one part remains independent, existing in the form of elementary sensations or images, or else aggregates more or less completely and tends to form a new system, a

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[47] *Revue philosophique*, 1886, t. II, p. 582.
[48] *Anesthésie systématisée et dissociation des phénomènes psychologiques*. (*Revue philosophique*, 1887, t. I, p. 450 and 1888, t. I, p. 254.) For the history of these studies on automatic writing, see *Autom. psych.*, p. 376.
[49] *Revue philosophique*, 1888, t. I, p. 267. — F. Myers, *The subliminal consciousness, sensory automatism and induced hallucinations*. (*Proceedings of the Society for Psychical Research*, 1892, p. 436.)
[50] *Les actes inconscients et la mémoire pendant le somnambulisme*. (*Revue philosophique*, 1888, t. I, p. 265. Autom. psych.*, p. 410.)
[51] *Automatisme psychologique*, p. 332.
[52] Ch. Richet. — *Les mouvements inconscients dans l'hommage à Chevreul*, 1886, p. 93.

personality independent from the first. These two personalities do not merely alternate or follow one another—they can coexist in a more or less complete way.

A large number of hysterical accidents are connected to this type of hemisomnambulism, just as attacks are connected to the type of somnambulism. We have been forced to recognize that in many accidents, the fixed idea which, according to M. Charcot's theory, should provoke and sustain them could not be expressed by the patient, for he was completely unaware of it. We now understand that these ideas can exist within him even though he has no consciousness of them, and this is not merely a plausible supposition—it is a fact that can be demonstrated clinically. How many times have we shown that the subject, during automatic writing in the waking state, could express these fixed ideas? Even more frequently, we have found that the subject, in such-and-such a hypnotic state, completely recovered the memory of these subconscious fixed ideas.

Such fixed ideas, existing outside of personal perception, play a central role in hysteria; they can produce the most varied motor disorders, give rise to hyperesthesias, and even lead to hallucinations, for the separation of the two consciousnesses is far from absolute and a phenomenon once provoked in one system of ideas can suddenly appear in the other. These ideas can disturb and obscure the mind, cause the strangest forgettings, and even kinds of delirium. A few years ago, we analyzed a case of this kind in which a large number of accidents were linked to subconscious fixed ideas. "It would be necessary," we said at that time, "to review all of mental pathology and a large part of physical pathology to show all the psychological and bodily disorders that can be produced by a thought persisting in this way outside of personal consciousness."[53] The power of these ideas depends precisely on their isolation. The ideas of a normal man are numerous and constantly interfere with one another because they are all part of the same consciousness; but in hysterics this is not the case, due to the dissociation that fractures their mental unity. As M. Charcot observed, some centers can act without the others being informed of the operation and yet participate in the process.[54] These ideas grow, "take root in the mind like a parasite," and cannot be halted in their development by the subject's efforts, because they are ignored, because they exist apart in a second thought, separated from the first. These remarks had already led us to consider these dissociations of psychological phenomena as an essential characteristic of hysteria: "This fact," we said, "must play in this illness a role as central as that of association in normal psychology."[55] A little later, we explained various hysterical accidents and especially their recurrences "by the real activity of a second group of images separated from normal consciousness."[56] "*The essential character of this disease of disaggregation is the formation in the mind of two independent groups of*

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[53] *Automatisme psychologique*, 1889, p. 436. — Same remarks regarding another patient in a case of aboulia and fixed ideas. (*Revue philosophique*, 1891, t. I, p. 280.)

[54] Charcot. — *Mal. du syst. ner.*, III, p. 455.

[55] *L'anesthésie systématisée et la dissociation des phénomènes psychologiques*. (*Revue philosophique*, 1887, t. I, p. 472.)

[56] *Automatisme psychologique*, 1889, p. 362.

representations, thus constituting an ordinary personality and a second one, which may in turn subdivide into a distinct abnormal personality, different from the first and completely unknown to it."[57]

At the same time, M. Jules Janet, in order to summarize the research we had carried out, published a particularly interesting case study, and he sought to express this new conception of hysteria.[58] One might perhaps reproach this work for being a bit too schematic, but it has the great merit of clearly summarizing a rather delicate psychological conception which, at the time, was very poorly understood. *"The incomplete state of the first personality,"* he says, *"constitutes the hysterical defects; it allows the disordered action of the second personality—that is, the hysterical accidents... the second personality, always hidden behind the first, all the stronger as the first is more weakened, takes advantage of the slightest opportunity to overthrow it and appear in full view."*[59]

A large number of psychological studies were later carried out on this doubling of personality, but we will summarize only those that align with the medical conceptions of hysteria. M. Laurent, in a study first published in the *Archives cliniques de Bordeaux*[60] and later expanded in his doctoral thesis,[61] shows the major role played in hysteria by secondary states and subconscious phenomena, which he considers as characteristic of the disease. But the most important work that has recently confirmed our earlier studies is without a doubt the article by MM. Brener and Freud, recently published in the *Neurologisches Centralblatt*.[62] We are very pleased that these authors, in their independent research, have been able to verify our results with such precision, and we thank them for their kind citation. They show by many examples that the various symptoms of hysteria are not spontaneous, idiopathic manifestations of the illness, but are closely connected with a provocative trauma. The most ordinary accidents of hysteria—even hyperesthesia, pain, or mild attacks—must be interpreted in the same way as the more dramatic accidents of traumatic hysteria, caused by the persistence of an idea, of a dream. [63] The relationship between the provocative idea and the accident may be more or less direct, but it always exists.
It is often observed, however, that when the patient is in their normal state, the provocative idea is no longer apparent—it is only found during the periods of natural or provoked altered states, and it is precisely then that the patient expresses it in all its power. The patient says, in effect, that these ideas had power over him without his conscious awareness of the fixed idea. "*This division of consciousness that has been clearly observed in certain famous cases of double existence exists in a rudimentary way in every hysterical subject. The disposition*

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[57] *Ibid.*, 1889, p. 367.
[58] Jules Janet. — *Hystérie et hypnotisme d'après la théorie de la double personnalité*. (*Revue scientifique*, 1888, t. I, p. 616.)
[59] Jules Janet, *op. cit.*, p. 622.
[60] L. Laurent. — *De l'état mental des hystériques d'après les théories psychologiques actuelles.* (*Archives cliniques de Bordeaux*, September, 1892.)
[61] L. Laurent. — *Des états seconds, variations pathologiques du champ de la conscience*, 1892.
[62] Josef Brener & Sigm. Frend in Vien. [Janet's misspelling] — *Ueber den psychen mechanismus hysterischer Phänomene.* (*Neurologisches Centralblatt*, 1893, nos 1 and 2.)
[63] Brener & Frend [Janet's misspelling], *op. cit.*, *Separat abdruck*, 3.

to this dissociation and simultaneously to the formation of abnormal states of consciousness—which we propose to group under the name of hypnoid states—constitutes the fundamental phenomenon of this neurosis."[64] This definition confirms those we have already offered, which seek to organize all the symptoms of the illness around one principal phenomenon: the doubling of personality.

III. The Narrowing of the Field of Consciousness

The previous definitions certainly have a broad generality; they apply to the majority of hysterical incidents. But it is clear, on the other hand, that they leave almost completely aside other equally numerous and very important features—I mean the hysterical stigmata. As these patients have been studied more extensively, increasing attention has been drawn to the importance of certain symptoms that seemed to be hidden, of which the patients did not complain, and which nevertheless persisted at the same time as the incidents or even in their intervals. These essential, permanent, non-painful symptoms of the illness are mainly composed of various disturbances in sensation, memory, and will, which manifest as changes in movement and character. It is impossible for a general definition of hysteria not to take them into account.

Certain authors have tried to apply to the stigmata the same explanation as to the accidents, and to likewise connect them to fixed ideas. Certain patients, in fact, seem to have a more or less clear thought relating to their amnesias or to their motor weakness; others, as has been quickly noticed, only display their stigmata at the moment they appear and they pay attention to them, and no longer display them when they are distracted. We think we've caught them off guard, when they are no longer thinking of playing the comedy of insensibility or of amnesia, and we easily conclude that these stigmata are sorts of fixed ideas that appeared by accident.

This explanation would be simple, in line with the principles we have stated, but we regret that we cannot accept it; the observation of a large number of regular and easily observable facts prevents us from assimilating the stigmata—anesthesia, for example—to symptoms caused by fixed ideas.

(1) There is always a precise event at the beginning of the accident related to a fixed idea, but we find nothing in the patient's history that would allow us to trace back the idea of not feeling the left side or of having a narrowed visual field.

(2) The accidents related to fixed ideas are known to the patients; stigmata are so indifferent to the patient that they are often ignored.

(3) It is true that certain fixed ideas are subconscious, but the thought is recovered in somnambulistic states or by means that allow one to detect subconscious phenomena; never have such procedures allowed us to detect a fixed idea related to the stigmata.

(4) The thought of the accident determines the nature of the symptom—in other words, the illness realizes its symptom as it thinks of it. On the contrary, we find in stigmata very complicated characteristics of which the subject has no idea.

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[64] *Ibid.* — The authors add, *p. 4*, without noting that these ideas also resemble those of Benedikt. We regret not being familiar with that work.

Should we suspect the bizarre disturbances of movement we see with muscular anesthesia? Was the notion of this syndrome known to Lasègue, who observed something similar in patients admitted to the hospital?

(5) Since fixed ideas are accidental and personal, they are variable; one cannot count the strange behaviors one encounters, and new ones always turn up that had not previously been observed. But the stigmata are perfectly regular and are repeated using the same methods up to today in all the countries where they are observed.

(6) Finally, we have already remarked that fixed ideas only develop in advanced stages of the illness. Dissociation by suggestion—aside from special cases—does not occur in a period where fixed ideas could not yet have that strength and persistence.

No doubt in some cases, characteristics partially analogous to stigmata—anesthesias or movement disorders—may be produced by suggestion.
But we believe this is not the natural formation of these symptoms.
Most often, they are not accidental but follow general laws which we must try to determine.

The stigmata present themselves as weakenings, as at least apparent suppressions of sensations, memories, movements. (Hyperesthesias and contractures are not, for us, in the most ordinary cases, true augmentations of the senses or of movements. Hyperesthetic patients actually feel very little pain, and those with contractures do not make movements as forceful as one might think. Moreover, these phenomena are almost always accidents due to fixed ideas.)
If the stigmata always have this character of a sort of negativity, one can obviously consider them as evidence of a weakening of nervous functions, of an exhaustion of organs. This is not a theory; it is the just about banal expression of the fact itself—it remains to interpret the nature of this exhaustion.

For us, the question is posed as follows: is this exhaustion localized in a specific sensory organ, or does it affect the upper parts of the brain in a more general way? Can one say that tactile anesthesia or the narrowing of the visual field are directly related to a cessation of function in the nerve centers that serve those tactile or visual sensations? Or are these anesthesias merely particular manifestations of a broader weakening affecting all the functions of the cerebral cortex, and are they therefore connected to a general disturbance of psychological functions?

We do not believe that the stigmata are due to local lesions of the sensory organs, muscles, nerves, or centers:

(1) The stigmata are too mobile; they disappear too easily as soon as one modifies the subject's thought even slightly. Suggestion, association of ideas, and especially attention eliminate these anesthesias and muscular impotencies as if by enchantment.

(2) The stigmata are contradictory, that is to say, the functioning of the organs is real and persists even when it appears to be suppressed.

We have known many cases where sensation remained intact, even at the periphery of the visual field, continued to function, where memories were recovered despite apparent amnesia, where movements were possible and strength

preserved despite weakness, as shown by the dynamometer, even when the patient appeared to have lost will.[65] These facts have been demonstrated by a large number of precise experiments, but can also be observed through the simplest clinical observation. Hysterical patients, walking alone, without falling, without bumping into obstacles, should collapse from their anesthetized limbs; patients with visual narrowing should, according to their own claims, see no more than a pinhole field. Yet we see them working, lifting burdens, performing prolonged exercises if they are not being observed, while as soon as they are watched they display astonishing muscular weakness and extreme fatigue when only slightly exerted. We were pleased to see that Mr. Jolly made the same observations independently and noted: "He speaks of children who appear to have complete blindness and adds: 'These children in passing do not notice any light, avoid obstacles indefinitely in front of them, yet do not collide with them by touch... they do not resemble blind children... I have many reasons to believe that this deafness is not real... it is not possible for me that the child heard people without hearing me."[66] H. Oppenheim also writes: "Hysteria can rob the will of the ability to command certain muscle groups... it is something other than the paralysis of muscles by a defect of will or by the intermediary of an affected center."[67] This dissociation and this contradiction of phenomena prevent us from believing in a localized exhaustion.

The general exhaustion of cerebral functions has been noted by many authors. "Hysterics," said M. Féré, "are in a permanent state of psychic fatigue which results in a weakening of the sensitivity of voluntary movements…"[68] M. Féré resumed this study in great detail in a recent book on "the pathology of emotions." While we cannot accept all of this author's opinions on localized exhaustion of nervous centers—which still seem quite hypothetical to us—we have always adopted his ideas regarding the general exhaustion of the nervous system in hysterics. "The fundamental fact of hysteria," says M. Oppenheim, "is irritable weakness, an abnormal excitability joined with exhaustion; these characteristics are especially evident in the sphere of affective phenomena."[69] M. Jolly, adopting Oppenheim's conception, also speaks of an undeniable nervous weakness that allows the exaggeration of affective phenomena, but he adds that this formula lacks precision and does not capture specific facts.[70] We agree with this author that it is necessary to specify what is meant by this cerebral weakness. It is not enough to say—though it is obvious—that the hysteric is cerebrally weakened, for there are a thousand varieties of cerebral weakness, and one must, as far as possible, show what is specific to the hysteric. Since the essential functions of the brain are psychological functions, they must be studied through the analysis of moral phenomena, in which this psychological insufficiency consists.

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[65] These works, already old, published in 1886 and 1887 and whose details we cannot return to here, are summarized in our latest book on the mental stigmata of hysterics.
[66] Jolly, *op. cit*., p. 4.
[67] Oppenheim, *op. cit*., p. 6.
[68] Féré. — *Sensation et mouvement*, 1887, p. 21 and *Pathologie des émotions*, 1872, p. 138.
[69] Oppenheim, *op. cit.*, 1889, p. 3.
[70] Jolly, *op. cit.*, p. 12.

We once proposed studying a psychological phenomenon that had already been mentioned, somewhat vaguely, among the character disturbances of hysterics, but which seemed to us the principal expression of this insufficiency. It concerns a weakness of attention, or rather a state of perpetual distraction, which can be easily observed in most of these patients. Their attention is slow to fix, laborious, accompanied by all sorts of disturbances, quickly exhausted, and yields very minimal results—it produces only vague, doubtful, surprising, and unintelligible ideas.[71] When attention is considered in its motor aspect, as applied to actions, the same traits are found: voluntary acts are laborious, slow, of short duration, and interrupted by countless stops. Often this already feeble attention seems to disappear entirely, every intellectual effort, every voluntary act becomes impossible, and the subject is no longer capable of understanding what they read or hear, nor even of performing the smallest voluntary movement. Forgetfulness, aprosexia, hesitation, doubt—we believe we must emphasize—are the essential psychological features of hysteria. These traits may also appear, to some degree, in other patients, that is evident, but this is no sufficient reason to neglect them in the hysteric.

These attention deficits are so severe that they interfere not only with intellectual work, but also alter even the most basic aspects of life. The patient struggles to maintain continuous attention to even a simple task. He notices things happening around him only vaguely, and more importantly, he feels that he is barely aware of anything; he seems to always forget most of the impressions that should strike him.[72] If one seeks to examine this mental state more precisely, one finds that a hysterical woman cannot perceive multiple sensations at once: if she is occupied with one phenomenon, she becomes indifferent to all other stimuli, even those that are typically quite perceptible. She exhibits the same inattention with regard to memory, forgetting the opposing ideas she knew only a moment earlier. Her motor actions also reflect this same distracted nature: she cannot voluntarily perform a movement and, if she stops seeing or feeling something, she is immediately distracted by another sensation or movement. This last point has been particularly studied in an interesting paper by Mr. Pick.[73] Such distractions rarely occur in normal individuals, and only result from excessive concentration of thought on a complex problem; in hysteria, however, they occur in a much simpler way. "It is an exaggerated state of *distraction*,[74] which is not momentary and does not arise from voluntary attention being focused in one direction; rather, it is a state of natural and perpetual distraction that prevents these individuals from appreciating any sensation other than the one currently occupying their mind."

We have previously attempted to explain, to summarize all these numerous facts in a simpler form. Psychological life is not merely constituted by a succession of mental phenomena, as in certain authors, forming a long chain that

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[71] *Les stigmates mentaux des hystériques*, p. 137. — *Ibid.*, p. 123.
[72] *Automatisme psychologique*, p. 188.
[73] A. Pick. — *Ueber die sogenannte "conscience musculaire"* (Duchenne). *(Zeitschrift für psych. und physiol. der Sinnesorgane*, vol. IV, 1892). Cf. *Stigmates mentaux de l'hystérie*, p. 156.
[74] *Autom. psych*., p.189.

continues in a single direction. Each of these successive facts is, in reality, very complex, containing a multitude of elementary facts and must be united not only by synthesis, but by the systematization of all these elements. We have proposed to call this a field of consciousness or maximum extension of consciousness—the number and degree of the mental phenomena or simple images that can occur at each moment, which all seem simultaneously linked to a particular personality.[75] This field of consciousness thus understood is variable. A conductor hearing all the instruments together and following by memory or reading the orchestral score brings together in his state of consciousness a vast number of facts. The sleeping individual who dreams, the patient during an ecstasy state, on the contrary, only brings into conscious thought a very limited number of facts. It is easy to see in the distraction of hysterics that their field of consciousness seems very small, and they seem wholly occupied by a single relatively simple mental sensation, a small group of motor images, and cannot include others at the same time.[76] This narrowing of the field of consciousness is only one manifestation of the general cerebral exhaustion that has been observed. This exhaustion is often described with little precision, so we say: *it is a more particular weakness consisting in the incapacity presented by the subject to easily gather and condense their psychological phenomena, to assimilate them into their personality*.[77]

This observation allows us to group together a large number of facts, of character traits that are often noted in hysterical patients. Their fleeting enthusiasms, exaggerated hopes quickly followed by disillusionment, irrational convictions, impulses, whims, and mood swings all seem to stem from the fundamental fact that they always fully commit themselves to the present idea, with no reserves, no mental restrictions that would lend moderation, balance, or transitions to their thinking. "It is still a narrowing of the field of consciousness," said M. Laurent,[78] "which must be attributed to the hysteric's surprise, astonishment, emotionality, and the intensity of impressions." A given impression can abruptly erase previously existing ideas; the hysterical patient finds herself in the situation of someone who suddenly learns or sees something completely unexpected. This impression, overriding other ideas and dominating intelligence, gives rise—depending on its nature—to astonishment, fear, or joy; it is not counterbalanced by anything, no reasoning intervenes, and the instinctive expression of the idea immediately manifests. The same remarks can be applied to the sudden impulses of these patients and their abrupt changes of mood; it is simply the slightly more precise psychological expression of what was once vaguely described under the name of irritable weakness.

We believe we can go even further, and that the stigmata—even anesthesia itself—can be considered as dependent on a psychological condition. Anesthesia behaves like distraction: it is variable, mobile, and often disappears when one can provoke a voluntary effort of attention from the subject. It is neither deep nor complete, since it leaves residual elementary sensations in the form of

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[75] *Autom. psych*., p.194.
[76] *Autom. psych*., p.195.
[77] *Autom. psych*., p.194.
[78] L. Laurent. – *Etats seconds*, 1892, p. 127.

subconscious phenomena that are easily verified in many cases. One can even produce, by distraction itself, insensibilities that display all the characteristics of hysterical anesthesia. When the distribution of anesthesia shifts—which is frequent—alternations of equivalence in the lost sensations are observed. "Sensitivity," said Cabanis long ago, "seems to behave like a fluid whose total quantity is fixed, and which, every time it is discharged in greater abundance through one of its channels, proportionally diminishes in the others."[79] If you force the subject, by drawing their attention, to recover sensitivity in the left side, they lose it on the right. If you obtain full tactile sensitivity, the narrowing of the visual field suddenly worsens, as I have observed many times without telling the subject. If you try to widen the visual field, tactile anesthesia increases. These changes happen in a spontaneous way, and some subjects seem to alternate between several equivalent forms of anesthesia. These alternations are found not only in anesthesia but also in other phenomena, and this is why hysterics are never truly cured when one or another of their symptoms is more or less fully suppressed. The weakness of their personal thought persists, and they lose on one side what they seemed to regain on another. The localization of anesthesia may depend on a suggestion or a fixed idea, but anesthesia itself—and the stigmata in general—are manifestations of insufficiency in personal perception, of a narrowing of the field of consciousness.

M. J. Héricourt, when summarizing our study on hysterical anesthesia, used a very apt expression that well conveys our idea: *"It is by a kind of laziness that the principal figure suppresses a whole series of sensations, those that are least indispensable to him, in order to limit the field of an activity he would sometimes struggle to sustain... This rejection of an entire group of troublesome psychic elements would constitute a kind of spontaneous psychological autonomy, of which there are, moreover, indisputable cases."* Thus, it is known that people who squint with one eye completely suppress vision in the eye affected by strabismus and in reality see only with one eye, even though both eyes are equally sensitive to retinal impressions."[80] We therefore believe that the stigmata can be summarized by the following formula: *"Things occur as if the elementary psychological phenomena were just as real and just as numerous as in normal individuals, but could not, due to the narrowing of the field of consciousness and the weakness of the faculty of synthesis, come together into a single perception or a single personal consciousness.*"[81]

This new conception, to which we have been led by the study of the stigmata, is far from being in opposition to the conclusions of our previous studies on the accidents. The splitting of the personality is rather the immediate consequence of this weakness of psychological synthesis. This weakness allows psychological phenomena to persist but does not unify them under the idea of personality. One can understand the facts of somnambulism and subconscious acts as secondary groupings, accessory systematizations of these neglected psychological

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[79] Cabanis. — *Histoire des sensations*, in *L'étude sur le rapport du physique et du moral*, complete works, 1824, vol. III, p. 153.
[80] J. Héricourt. — *L'activité inconsciente de l'esprit*. (*Revue Scientifique*, 1889, vol. II, p. 262.)
[81] *Automatisme psychologique*, p. 364.

phenomena: *"things occur as if the system of psychological phenomena that forms personal perception in all humans were, in these individuals, disaggregated and gave rise to two or several simultaneous or successive groups, most often incomplete and competing with each other for sensations, images, and consequently movements, which ought normally to be united in a single consciousness and a single power."*[82] Suggestibility itself and disorders by representation relate to this general conception; for the exaggerated development of certain ideas depends on their isolation, and this isolation is a consequence of the narrowing of the field of consciousness. The exaltation of automatic phenomena most often results from a decrease in the power of voluntary activity, which normally gathers the present phenomena at every moment of life. This entire set of ideas we had previously summarized under the term *mental disaggregation*, and it still seems, based on the preceding analyses, that this idea offers the best means of summarizing a great number of hysterical phenomena.

Several authors have accepted this summary of facts and have completed it with new examples. Mr. Pick considers *the diminution of the power of attention, the narrowing of personal perception, to which he adds the narrowing of motor impulse, as the characteristic of hysteria*.[83] Mr. Laurent expresses himself almost in the same way: "We say hysterical, because today it is the only scientific word to designate mental narrowing, the *minus habens conscientiæ*, if we may thus express the mental state of this very intelligent individual, perhaps, but whose mental faculties are all marked by a stigma more fixed certainly than any of those usually looked for in hysteria."[84]

The narrowing of the field of consciousness thus becomes the principal characteristic signaled in a new group of definitions of hysteria; it allows the facts contained in previous definitions to be summarized and adds to them a fairly large quantity of new facts, the stigmata in particular, which were not included in them.

IV. Hysteria, A Mental Illness

"We say boldly," wrote Brachet in 1847, "no, the brain is not essentially damaged in hysteria."[85] Since that time, opinions have changed remarkably; it is now rare to find doctors who still consider hysteria to be a disease of the genital organs and who remove women's ovaries to cure them of their fixed ideas. "It is evident," says M. Jolly, "that over time the theory of hysteria has drawn increasingly closer to a psychic interpretation."[86] "Segmental limb paralyses," said M. G. Guinon, "are cerebral phenomena, as is hemianesthesia; the mental state—a significant syndrome in hysterics—directly reflects a disturbance in brain function. It must therefore be admitted that hysteria is a particularly cerebral neurosis."[87] "Hysteria," writes M. Sollier, "is merely a way the brain functions;

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[82] *Automatisme psychologique*, p. 364
[83] Pick, *op. cit.*, 1892, p. 190, 208.
[84] Laurent. — *Les états seconds*, 1893, p. 154.
[85] Brachet. — *Hystérie*, p. 294.
[86] Jolly, *op. cit.*, t. II.
[87] Georges Guinon. — *Les agents provocateurs de l'hystérie*, 1889, p. 354.

there is no such thing as a hysterical disease… it is the cerebral mechanism that is hysterical, not the affliction itself."[88] In the recent dictionary of mental medicine by M. Hack Tuke, both articles devoted to hysteria reach the same conclusion. "Hysteria," according to M. Donkin, "is a disorder or defective development of the highest functional centers of the cerebral cortex… One is less likely to go astray by considering hysteria a kind of madness than by trying to group its phenomena around a physical symptom of the disease."[89] In the same work, MM. Charcot and Marie also associate hysteria with a disturbance in the functioning of the highest cerebral regions. Hysteria is less, according to them, a disease in the usual sense of the word than "a particular mode of feeling and reacting."[90] All the studies we have conducted so far likewise lead us to classify hysteria among the group of mental illnesses. However, we must examine the difficulties posed by such an assimilation—not to resolve them completely, but to understand the practical value of our provisional definition of hysteria.

To critique our definition that tends to classify hysteria as a mental illness, we may be allowed to follow an old method that dates back to scholasticism, but which is quite precise: "Conveniât toti et conveniât soli definitio,"[91] was said of a definition. We will first examine whether previous conceptions are broad enough to apply to all cases of hysteria—that is, whether they encompass all the symptoms that these patients may present—and then whether they are precise enough to characterize hysteria alone and distinguish it from other mental illnesses.

Let us first consider the first point: does the conception of hysteria as a mental illness summarize all the symptoms of this illness? No doubt a large number of phenomena previously described as physical are today regarded as psychological: paralyses, contractures, choreas, hyperesthesias, anesthesias are moral symptoms. But there exist other hysterical incidents whose psychological interpretation is much less advanced and even much less plausible: we believe we can classify them into three principal categories: (1) the visceral accidents of hysteria; (2) the vaso-motor and secretory disturbances; (3) the trophic disorders.

"Visceral accidents are very numerous in hysterics and, in fact, in some patients, they are the predominant feature. Let us recall cardiac palpitations and even certain alterations in the rhythm of the heartbeat, hysterical fever as signaled by Briquet[92] and which, today, would attract attention, dry coughs, nosebleeds, hiccups, and all kinds of modifications to the respiratory rhythm. These patients have often appeared to breathe in a peculiar way, of a particular type of respiration, the so-called costo-superior type; the lower ribs and the diaphragm seem almost completely immobile, and disturbances in diaphragm movement are indeed extremely frequent and probably play a large role in certain cases such as abdominal tympanism.[93] However, it is known that the most frequent accidents

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[88] Sollier. — *Amnésies*, 1892, p. 323.
[89] Donkin. — *Hysteria : Dictionary of psychological medicine*, t. I, p. 619.
[90] Charcot and Marie. — *Hystéro-épilepsy : Dictionary of psychological medicine*, t. I, p. 628.
[91] Translates to "Let the definition fit the whole and only the whole"
[92] Briquet, *op. cit.*, p. 493.
[93] Interpretation by S. Talma (of Utrecht) and M. Bernheim, *hypnotisme, suggestion*, 1891, p. 191.

affect the digestive system. It is easy to observe abnormalities of various kinds, swallowing disorders, spasms of the esophagus at various levels, vomiting, more intense phenomena such as diarrhea or, quite to the contrary, constipation, abdominal bloating, sphincter paralysis or spasms, and urinary disorders of the same kind as those affecting bowel movements or urine secretion. Hysterical ischuria is one of the most important of these phenomena: 'the capital fact is a considerable reduction in the amount of excreted matter despite the presence of urea in the vomit."[94]

The alterations of vasomotor functions are already evident in the common disturbances of menstrual phenomena, in those supplementary and peculiar hemorrhages that occur through the nose, the stomach, and even the lungs. But they can also be observed on the surface of the skin and in the peripheral organs. Many patients have slightly raised red patches on the skin that appear before or after attacks and persist for a varying length of time; many present with a noticeable swelling of the vascular glands. Vascular goiter is frequent among hysterics, and in some, it develops suddenly following an attack or an emotion. Finally, vasomotor reflexes are not always normal—though we are not speaking here, of course, of physiological experiments, which are, as is known, extremely debatable, but of simple clinical observations: needle pricks do not bleed, even light pinches cause exaggerated bruising, the application of a slightly heated object causes burns, etc., and these phenomena are not identical depending on whether one operates on the anesthetic side or the sensitive side. Finally, it is sufficient to mention the curious phenomena of dermographism. We do not intend to analyze all these observations here, we simply wish to recall them.

We are familiar with the astonishing observation of milky secretion, reported by Briquet,[95] which might be likened to cases of "irritable breast" noted by several authors. But without seeking out such rare observations, one finds that disorders of secretion are quite common among hysterics. The magnetizers had made some rather accurate remarks on this point. "I will also point out," said Despine, "some phenomena of the skin that seem to relate to the non-perspiring nature generally seen in seriously ill patients with nervous disorders, and which I encountered among all my cataleptics: the dryness and brittleness of the hair, the burning heat of the skin... the lack of any odor from the scalp, as well as the armpits and feet..."[96] Indeed, it is true that the usual secretions are often very diminished, but the opposite fact can also be observed: we knew of a hysterical woman, anesthetic throughout her entire body, who for two years continually produced extraordinary sweats, capable of soaking her clothing, and these sweats only disappeared suddenly when delusional attacks developed as the result of an emotion. Have not even colored sweats been reported in hysterics?[97] All other secretions may also present pathological alterations.

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[94] Charcot. — *Maladies du système nerveux*, t. I, p. 278, 296.
[95] Briquet, *op. cit.*, p. 481.
[96] Despine (d'Aix). — *Traitement des maladies nerveuses par le magnétisme*, 1840, p. 222; same remark in the curious work of Dr. Pététin on *l'électricité animale*, p. 110.
[97] V. Fouré. — *De la chromhidrose*, thèse 1891, p. 42.

Precise studies on hysterical atrophies are recent, but the fact, in general, is of older observation. Despine (of Aix), in the same passage we have just cited, also described—perhaps with a bit of naïveté—"the extraordinary hairiness of the legs, far greater than what is common in women, the almost complete absence of nail growth on the fingers and toes, and especially in the limbs that are most subject to paralysis... One female patient herself remarked that she only had to trim the nails on her left hand once, while she had to cut them three times as often on the right hand."[98] It is enough to recall the fine work of M. Charcot, M. Babinski, and MM. Gilles de la Tourette and Dutil on muscular atrophy in hysterics. These are phenomena which, in our opinion, still require study, but which today seem able to be legitimately connected to hysterical illness.

This brief summary simply aims to show that in linking hysteria to the group of mental illnesses, we must not forget the numerous organic symptoms found in these patients. How should we interpret these facts? Must new discoveries make us abandon previous definitions? Let us first note that some of these facts must probably be linked to persistent ideas, more or less consciously held, such as the paralyses and contractures explained by M. Charcot. By showing the importance of isolation in treating hysterical anorexia, M. Charcot demonstrated that the psychic element plays a predominant role in this illness.[99] "In our view," wrote M. Sollier, "there is only one nervous anorexia; it is mental anorexia."[100] We might have a few reservations here, since not all anorexias are alike; many patients refuse food due to fixed ideas, while others accept food but reject it due to certain spasms of the esophagus, stomach, diaphragm, or even abdominal muscles. Nevertheless, these spasms themselves can be more or less directly provoked and modified by the subject's ideas, as can be clearly shown through suggestion experiments. Experiments of this kind have caused modifications in menstruation, severe vascular disorders capable of producing on the skin erythema like that from sinapisms or blistering burns.[101] No doubt these experiments need to be redone, verified, and interpreted, but at the very least they show that we do not yet fully understand the enormous influence of thought on the body. Many of the organic phenomena we have described may later be shown to be tied to fixed ideas, even altering visceral functions.

A second category of facts may be interpreted differently: hysterics do not only have fixed ideas, they have persistent emotions, and these emotions are complex states of the whole organism in which physiological and psychological phenomena are intimately mixed. Certain physiological disorders of hysteria closely resemble the disturbances that accompany emotions. Oppenheim and Strümpell[102] have rightly emphasized this point. Is it necessary to recall emotional erythema, dry mouth during fear, vomiting from disgust, emotional jaundice, etc.? Our knowledge of the psychology of emotion is insufficient to explain the details

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[98] Despine (d'Aix), *op. cit.*, p. 222.
[99] Charcot. — *Maladies du système nerveux*, t. III, p. 238.
[100] Sollier. — *L'anorexie hystérique.* (*Revue de médecine*, 1891, p. 626.)
[101] Many of these experiments are summarized in an interesting manner in the work of Mr. Myers, *Subliminal Consciousness.* (*Proceedings of the Society for Psychical Researches*, 1892, p. 308.)
[102] Oppenheim, *op. cit.*, 4. Strümpell, *op. cit.*, 7.

of these facts, but we have enough reason to believe that this line of study will later account for many modifications that appear purely bodily, and this category of phenomena will once again be linked to our general conception of hysteria.

If there remain unexplained phenomena—and we believe that there are—it is necessary, in order to understand them, to recall certain general remarks that have been made about all mental illnesses. These illnesses depend on unknown alterations of the brain, and it is unlikely that these alterations, whatever their unknown cause, are absolutely isolated within an otherwise healthy organism. The actions and reactions of the various parts of the nervous system, and even of all the organs upon each other, are too numerous for a deficiency in cerebral functioning not to be accompanied by many other disorders. These are observed in melancholia and mania, which are nevertheless considered mental illnesses—so why should we not also observe them in hysteria? Nutritional deficiencies, reduction in excretory matter, anemia, even a predisposition to infectious diseases which are in some cases evident, do not surprise us at all in this illness. Perhaps one day the physiological modifications that accompany cerebral deficiencies will be determined precisely enough to allow us to identify a fundamental physiological phenomenon to which all the details of persecutory delusion could be linked, and another by which all the phenomena of hysteria could be precisely explained. Then there would be a physiological definition of hysteria. But we believe that today such a definition would be extremely vague and would not clearly include the characteristic phenomena of the illness. If it is accepted once and for all that a mental illness is a brain illness and is always accompanied by a host of pathological phenomena, one will understand that a psychological definition is still today the best formula capable of summarizing the great majority of hysterical symptoms.

Let us now consider the problem from another angle: this conception of hysteria, which is broad enough to encompass most known symptoms—has it not now become too broad, and does it not include under the heading of hysteria a number of incidents that actually belong to other diseases? It is undeniable, as M. Moebius quite rightly remarked,[103] that in recent years the domain of hysteria has significantly expanded. This term was initially applied only to women presenting with pains, symptoms related to the genital organs, and particular attacks—that is, in reality, to a small number of patients; then it was applied to children, to men, to patients without genital disorders and without attacks, and finally to a much larger number of individuals. We observe this expansion and believe it will continue, and that many tics, pains, and fixed ideas will soon be very legitimately linked to hysteria. This is a curious fact in the history of medicine; it has a significant meaning and shows the increasingly important role assigned in pathology to mental phenomena, and the growing importance of psychiatry. No doubt there will come a time when hysteria will be broken down, and it is not impossible to foresee even now certain subdivisions that will be established later. This has been the case in all major medical classifications, for nephritis and atrophies as well as for mental illnesses. This should not stop us from doing the work that is still

[103] Moebius, *op. cit.*, p. 5.

useful today, which is to try first to understand the common characteristics of large groups. We therefore wish to clarify how and to what extent we are prepared to broaden the scope of hysteria.

One of the discussions about the limits of hysteria was provoked by the study of somnambulism. Since interest in this phenomenon arose, it has been recognized that it can be observed and even provoked in a large number of people, leading to the question of whether these people were ill and, if so, what their illness was. To study this question, we must first make a distinction more necessary today than ever: we are speaking of somnambulism and not of hypnotism. That word has lost all precise meaning—it applies equally to the child who sleeps, the patient who drinks his potion, the subject dazed by sustained fixation, and the hysteric in an ecstatic attack. We in no way deny that the observation of all these very real facts may provide interesting details for the study of sleep, faith, vertigo, attentional fatigue, etc. But we are not studying all these questions here; we are speaking of one particular and much more precise fact: somnambulism proper. For us, somnambulism is a second psychological existence clearly distinct from the first and alternating with it. It is a state in which intellectual phenomena are sufficiently developed for the subject to perceive sensations, even understand signs and language, yet it is nonetheless followed by complete amnesia when the subject returns to the normal state, and these memories reappear only in another analogous state. No doubt, there are a thousand degrees and complications of these phenomena, but no medical or scientific discussion can be based on doubtful and indistinct phenomena, and we must first speak only of the most indisputable somnambulism.

If we consider only somnambulism as defined by us, it is easy to notice that it almost always occurs in subjects already presenting a whole set of symptoms belonging to hysteria. The magnetizers, who were well acquainted with somnambulism, had already observed this. Despine insisted on it several times;[104] he even added a remark that we consider important: that even in hysterics, somnambulism disappears when the nervous illness is cured.[105] “It is especially nervous and hysterical diseases,” also said Noizet, “that produce the most artificial somnambulists.”[106] Later, Mr. Gilles de la Tourette,[107] Mr. Babinski,[108] Mr. Blocq,[109] and Mr. Laurent,[110] expanding on the teachings of Mr. Charcot, enumerated all the hysterical symptoms that one encounters in somnambulists. Most of the foreign authors whose works we have studied in this report arrive at the same conclusion: According to Mr. Strümpell, “hysterical states and manifestations are so closely united.”[111] For Messrs. Breuer and Freud, “hypnoid states and hysterical phenomena are closely united by a narrow link.”[112] “It is

[104] Despine (d’Aix), *op. cit*., p. 86 ; — Despine (de Marseille), *Le somnambulisme*, 1880, p. 140.
[105] *Automatisme psychologique*, p. 343, 446.
[106] Général Noizet. — *Le somnambulisme*, 1854, p. 187.
[107] Gilles de la Tourette. — *Hypnotisme et états analogues*, 1887, p. 55.
[108] Babinski. — *Hystérie et hypnotisme*. (*Gazette hebdomadaire*, July 1891, p. 15.)
[109] Blocq. — *Gazette des Hôpitaux*, January 23 1893.
[110] Laurent, *op. cit.*, 1892, p. 159.
[111] Strümpell, *op. cit.*, p. 18.
[112] Breuer & Freud, *op. cit.*, p. 7.

among hysterics," writes Mr. Donkin, "that the most examples of somnambulism are found… It is certain, according to general experience, that human beings are more easily hypnotized in proportion to their degree of nervous instability."[113] We must admit, with our limited experience, that we have never encountered true somnambulism without a set of hysterical symptoms. Mr. Charcot was therefore right to say from the beginning that somnambulism is a phenomenon that develops in hysterics.

But we believe that we can now go a little further: the hysterical phenomena have been analyzed with great care; we know what their nature is from a psychological point of view—they are characterized precisely by the splitting of personality, which exists in its highest degree in somnambulism. Somnambulism is not merely hysterical because it coincides with hysterical symptoms; in itself, it presents, in the most perfect way, the character of all the phenomena of this illness. If we were to observe a truly indisputable case of somnambulism in a person presenting (an almost contradictory supposition) no other pathological symptom, we would be inclined to declare them hysterical based on this single symptom which, in our view, summarizes all the others. We would have little hesitation in considering another still incompletely analyzed condition—ambulatory automatism or epileptic fugue. The description of this phenomenon, which we have not observed ourselves, closely resembles that of hysterical somnambulism, and its psychological diagnosis seems quite difficult to us. We have also taken a look with curiosity at a thesis by Mr. Saint-Aubin, which seemed to propose a discussion of this diagnosis;[114] unfortunately, the author does not describe any hysterics and does not address the problem directly. We are therefore forced to rely only on the vague signs indicated by Mr. Jules Voisin,[115] according to the clinical reports, about the nature of the accidents that precede or follow the secondary state. We particularly stress, with this author, the incoherent, disorganized nature of certain epileptic acts. A truly epileptic somnambulist must be of a very short nature, without reasoning, without intelligent or purposeful combination of actions, where the complete amnesia covers entire days during which the subject speaks and acts with full intellectual and affective development. Except for this difficulty which was rightly noted, we can conclude on this first point and say that somnambulism falls entirely within the domain of hysteria.

One could repeat the same discussion with regard to the automatic writing of mediums and to the hallucinations developed by "crystal gazing." These phenomena are most often observed in subjects who also present other hysterical symptoms;[116] and, moreover, these phenomena themselves exhibit what is essential in hysteria—anesthesias, amnesias, subconscious ideas, etc. It is important to agree on the terms and to speak a precise language, even if one is mistaken. For us, this division of personality which manifests in mediumistic

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[113] Donkin, *op. cit.*, p. 626.
[114] Louis Saint-Aubin. — *Des fugues inconscientes hystériques et diagnostic différentiel avec l'automatisme de l'épilepsie*, 1890.
[115] Jules Voisin. — *Distinction de l'automatisme hystérique et de l'automatisme épileptique*, *Congrès de médecine mentale*, 1889.
[116] Charcot, *op. cit.*, t. III, p. 228; *Automatisme psych.,* p. 404.

phenomena is precisely what we call hysteria, because it is found in all the other so-called hysterical phenomena and constitutes them. We therefore accept, on this point, the broadening of the concept of hysteria and include under it somnambulisms, automatic writings, and in general, all manifestations related to subconscious psychological phenomena.

If we continue these diagnostic studies, we encounter other mental states that should be compared with that of the hysteric. In certain intoxications—especially from hashish or alcohol—intoxication, drunkenness, and delirium often occur that closely resemble hysterical states. We have previously emphasized the high suggestibility and profound dissociation of personality observed during alcoholic delirium;[117] since then, M. H. Colin and M. L. Laurent[118] have published very precise observations of the same facts. We believe that in certain cases, the disintegration of the mind caused by alcoholism or other intoxication can be very long-lasting and may fully take on the form of hysteria; in such cases, whatever the provoking agent may be, it is necessary to recognize that we are dealing with hysteria.[119] But more often, the distinction must be made either by the nature of the delirium or more clearly by the transient character of the mental disaggregation. This diagnosis of hysteria and toxic deliria thus teaches us that an additional element must be added to the definition of hysteria: the duration—the persistence over a fairly long time—of the dissociation of consciousness.

The study of another category of patients raises a much more interesting and much more difficult problem to resolve. These are the many patients situated on the frontiers of madness, who present symptoms that appear very diverse, but among whom there are undeniable connections: delusional doubt, conscious or reasoning madness, obsessions, impulses, phobias, etc. These subjects, although very different, have almost always been grouped together by modern authors under a single heading, but this group has been given different names depending on the authors' theories. In France, following the example of M. Magnan, these afflictions are almost always designated as the delusions of degenerates; in Germany, they are called neuroasthenic patients; to avoid taking a position in a currently difficult discussion, and to distinguish ourselves from these specific labels, we will designate in a vaguer way all those people who at one time were observed to suffer and to whom it is fitting to give a name—we will simply call them psychasthenics. Among the psychasthenics—whom one often associated with neurasthenics, while still separating them from hysterics, simple neurotics, and even madmen—we ask whether hysteria itself, if it has remained distinct, and this other category of patients, should continue to remain in completely separate classifications from each other?

Obviously not. In our view, there are the closest connections between the two groups, and it is because these have often been overlooked that people have become entangled in endless discussions. First, it is impossible to deny that a very large number of patients belong simultaneously to both classes; many hysterics, as

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[117] *Actes inconscients… Revue Philosophique*, 1888, t. I, p. 251.
[118] H. Colin – *État mental des hystériques*, 1890, p. 39, 41. L. Laurent – *États seconds*, 1892, p. 35, 41.
[119] Georges Guinon – *Les agents provocateurs de l'hystérie*, p. 163.

Mr. Tabaraud[120] and Mr. Colin[121] have shown through excellent observations, have obsessions, impulses, and phobias of all kinds. I would even go a bit further than these authors by stating that the symptoms they identified in a few hysterics actually exist, more or less concealed, in almost all of them. It is even these fixed ideas, as Mr. Charcot once established, that account for the incidents of hysteria. Conversely, it is quite difficult to encounter a psychasthenic who is, so to speak, a pure type of this condition and who does not exhibit more or less distinct anesthesias, at least transient amnesias, subconscious acts—in a word, symptoms of hysteria. There even exist certain symptoms that are always shared by both categories of patients; these are the phenomena that depend on aboulia. Several people were surprised that, in our work on the mental stigmata of hysteria, we described disorders of will and attention, hesitations in voluntary movements, the inability of attention to grasp and retain ideas as stigmata of hysteria. They said these are symptoms belonging to the insane, characteristic of certain melancholics and especially of doubters and the obsessed. Perhaps—since we do not hesitate to acknowledge the accuracy of a critique—we did not state clearly enough that this symptom is not always characteristic of hysteria, that it must present in a particular way to serve as a diagnostic feature of hysteria, and that, in short, it is a banal symptom belonging to many mental illnesses?[122] But be that as it may, we do not believe this feature can be removed from the description of hysterics; it is found in these patients in its most extreme form, and it plays a central role in all their episodes: it is, as always, aboulia—that is, the diminished present synthesis of psychological phenomena—that enables the development of automatism, that is, the reproduction of past phenomena in the form of unconscious fixed ideas. Abulia is a common characteristic of hysterics and psychasthenics.

Even when one compares phenomena which, in these two patients, are unquestionably different, one will still note that an essential analogy always remains. It would not be impossible to classify the symptoms of these two patients in pairs, showing that to each hysterical symptom corresponds a psychasthenic symptom, not identical, but very analogous in its psychological mechanism. To anesthesias correspond distractions and errors of sensation; to amnesias of doubt, to paralyses, to hesitations of voluntary movement which are at times confused with deliria of contact, to contractures of fixed ideas, to convulsive attacks certain seizures of fixed ideas preceded by an anxiety aura, to somnambulisms even of bizarre periods where the patient no longer recognizes himself, finds his personality changed, etc., etc. If we study the mechanism of all these phenomena, we find, on both sides, the diminution of synthesis and the emancipation of automatic phenomena. It seems impossible to us to completely separate these two illnesses; we believe that they all belong to one same class of mental illnesses, very close to each other, and that we have proposed to call the illnesses of mental disaggregation. “We are inclined to believe,” let us say again, “that the phenomena of automatism and disaggregation depend on a given condition of illness, but which is not uniquely hysterical. This condition would instead be

[120] Tabaraud. — *Les rapports de la dégénérescence mentale et de l’hystérie*, 1888.
[121] H. Colin. — *L’état mental des hystériques*, 1890.
[122] We have, however, insisted on this point on several occasions. *Stigmates mentaux de l’hystérie*, p. 112, 231.

much broader than hysteria; it would include hysterical symptoms among its manifestations, but would also reveal itself through fixed ideas, impulses, anesthesias due to distraction, automatic writing and even somnambulism itself".[123] We are pleased to find ourselves in agreement on this point with several other authors who have also affirmed this relationship between the two illnesses. "*The majority of hysterics, if not all*," wrote M. Legrain, "*are hereditary degenerates*." And M. Tabaraud added: "*To go so far as to say that hysteria is only a part of degeneracy, and that it must therefore be considered only as one of its syndromes, is not an exaggeration*."[124] "Mental degeneration and hysteria," said Mr. Roubinovitch in a paper presented to the Medico-Psychological Society, "seem to have a mutual affinity... Hysteria thus appears to be the result of a logical evolution of degeneration."[125] The assimilation of hysteria and psychasthenia has struck all those who have studied the psychological nature of these two mental illnesses.

To bring together and classify is not to confuse, quite the contrary; we have no intention of entirely assimilating a simple hysteric with her anesthesias, attacks, and contractures to a psychasthenic who only presents doubts, impulses, and fixed ideas. There is not, between these two categories of facts, the great difference that was once supposed when it was said that the former were physical phenomena and the latter moral phenomena; in reality, these facts are all equally psychological, though significant differences may still exist even among psychological facts. The defect of mental synthesis, the disaggregation of the mind, does not present itself in the same way in both cases. In hysteria, the psychic phenomena, no longer able to be completely integrated, separate clearly into several groups that are more or less independent from one another. The personality cannot perceive all the phenomena, it definitively sacrifices some—this is a kind of automatism, and these abandoned phenomena develop in isolation, without the subject having any awareness of their activity. Thus, the anesthesia is clear, the amnesia is absolute, the attack and the somnambulism are clearly distinguished from the waking state, and the fixed ideas are neither expressed nor even known by the subject. The delirium exists in the subject's mind without them being aware of it, while they continue to speak with very reasonable language. A hysterical woman spits out all her food as soon as she puts it in her mouth; she appears to make reasonable efforts to eat and reject her food against her will, without any intention or thought of her own: observers believe, and she herself believes, that it is a swallowing disorder or simply a physical accident—it would seem inappropriate to declare her insane. Yet she is in the midst of full delirium; since her last attack, she has been continually dreaming that her mother, from above in heaven, invites her to come join her and commands her to die of hunger as soon as possible, and it is only this delirium that provokes the vomiting. But this delirium is separated from normal consciousness; it is subconscious, unknown to both the observers and the subject

[123] *Automatisme psychologique*, p. 151.
[124] Tabaraud, *op. cit.*, p. 28.
[125] *Annales médico-psychologiques*, 1892, t. II, p. 143.

herself. “Hysterics,” said Messrs. Breuer and Freud, “are reasonable in their waking state and insane in their hypnoid state.”[126] It is this clear separation of psychic phenomena that can be schematically expressed by saying that in hysteria there is the formation of two independent personalities; the disaggregation takes the form of a doubling of the personality.

It is entirely different with psychasthenics: mental disaggregation does not occur in the same way—it seems that the personality does not resign itself to the necessary sacrifices and only partially abandons phenomena to automatic development. There are no clearly defined anesthesias or amnesias; they are always incomplete and take the form of distraction and continual doubt. Instead of passing from one idea to another with extreme ease while entirely forgetting the previous idea, the psychasthenic remains perpetually undecided between the different ideas. The delusions, unfortunately for the patient, do not remain subconscious; they invade consciousness at every moment, blend with other ideas, and produce a much more considerable general disturbance of thought. The patient who comes to complain with groans that she thinks, despite herself, of deceiving her husband, and that she is obsessively haunted by this idea, certainly seems much more insane than the hysterical woman who vomits. The subject himself feels much more ill and never displays the hysteric’s indifference. Sometimes, although more rarely, disaggregation in the psychasthenic reaches the point of the formation of different personalities, but these are never as independent as in hysteria. The patient feels this development of another personality within himself, and speaks of it as possession, whereas in hysteria, the doubling is more complete, and the resulting personality seems more external to the individual than to the psychasthenic.

We cannot study here this new form of mental disaggregation which characterizes the psychasthenic, nor show its degree of severity and its consequences. It suffices to note that it is different from that which has been observed in hysterics. We may therefore conclude with M. Colin[127] that "hysteria has its marked place in the sun and that it has rules proper to it." It is not necessary to deny the moral character of hysteria in order to preserve its place; it is enough to distinguish mental illnesses from one another.

We have, in one respect, broadened the concept of hysteria by linking it to somnambulisms and subconscious acts, but we have limited the study of this illness by distinguishing it from deliria and alienations which appear to most closely resemble it. Mental disaggregation is more permanent in hysteria than in deliria; it is much more complete in this illness than in psychasthenic states.

Conclusion

We do not need to insist in this work on the etiology or the evolution of hysteria; it is enough to recall well-established notions. Pathological heredity

[126] Breuer & Freud, *op. cit.*, p. 8.
[127] Colin, *op. cit.*

plays an absolutely predominant role in hysteria,[128] as in all other mental illnesses, and taking the word in its broad sense, in the sense of Morel, we can say that this condition is a disease of degeneration. A very large number of circumstances act as "provoking agents" and come to manifest this latent predisposition through incidents: these are hemorrhages,[129] debilitating and chronic diseases, infectious diseases—especially typhoid fever—and in some cases auto-intoxications,[130] organic diseases of the nervous system,[131] various intoxications,[132] physical or moral shocks,[133] overwork whether physical or moral,[134] distressing emotions, and above all a succession of such emotions whose effects accumulate,[135] etc. It is easy to see that all these provoking agents have the same character: they weaken the organism and increase depression of the nervous system. There is one age in particular that is especially critical in this regard: the age of puberty. We are not speaking only of physical puberty, which indeed has great influence, but of a state that comes a little later and which could rightly be called moral puberty. It is an age that varies slightly depending on countries and environments, in which all the greatest problems of life arise simultaneously: choosing a career and the concern of earning one's living, all the problems of love, and for some, all the problems of religion—these are the preoccupations that invade the minds of young people and entirely absorb their limited thinking capacity. These countless influences reveal a psychological insufficiency that remains latent during less difficult periods. In a mind predisposed by hereditary influences, this *psychological insufficiency* develops, takes form in a particular manner, and manifests as the set of symptoms known as hysteria.

The word "hysteria" must be preserved; it would be quite difficult nowadays to change it,[136] and truly, this name has such a great and beautiful history that it would be painful to give it up. If the etymology were too troublesome, it would be better, as Mr. Charcot very rightly said, to change the word "uterus" rather than the word "hysteria." But since each era has given it a different meaning, let us seek the meaning it has today for some authors.

To attempt to summarize what we have drawn from all these recent studies on hysteria, it suffices to gather the conclusions from our preceding paragraphs. *"Hysteria, we can say, is a mental illness belonging to the considerable group of degenerative diseases. It has only rather vague physical symptoms, consisting primarily of a general decline in nutrition, and is above all characterized by moral symptoms; the main one is a weakening of the faculty of psychological synthesis, a narrowing of the field of consciousness; a certain number of*

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[128] Briquet*, op. cit.,* p. 84. Georges Guinon, *Les agents provocateurs de l'hystérie,* 1889, p. 285; Pitres, *op. cit.,* t. I, p. 16, etc.
[129] Briquet*,* p. 111. Guinon, p. 121.
[130] Guinon, p. 77. Dutil. — *Hystérie et neurasthénie associées. Gazette médicale de Paris*, 1889, p. 29.
[131] Guinon, p. 218. — Souques. *Syndromes hystériques simulateurs,* 1861, p. 54. — Babinsky. *Association de l'hystérie avec les maladies organiques du syst. nerv.* (*Bull. et mém. de la soc. méd. des hôpitaux,* 11 nov. 1892.)
[132] Guinon, p. 136, et s. q.
[133] *Charcot. — Mal. du syst. nerv.,* t. III, p. 269. Guinon, p. 263.
[134] Dutil, *op. cit.,* p. 27. — Souques, *op. cit.,* p. 17. — Jolly, *op. cit.,* p. 9.
[135] Guinon, p. 11. Breuer & Freud, *op. cit*., p. 3.
[136] Moebius, *op. cit.*, p. 1.

elementary phenomena—sensations and images—cease to be perceived and seem to be removed from personal perception, which constitutes the stigmata; the result is a tendency toward the permanent and complete division of the personality, to the formation of several groups of phenomena independent of one another; these systems of psychological facts alternate in sequence or coexist, which gives rise to attacks, somnambulisms, subconscious acts; finally, this defect of synthesis favors the formation of certain parasitic ideas which develop completely and independently outside the control of personal consciousness and which manifest through the most varied disorders of seemingly purely physical appearance, that is, through accidents." If one wishes to summarize this somewhat complex definition in a few words, one could say: *"Hysteria is a form of mental disaggregation, characterized by a tendency toward the permanent and complete doubling of the personality."*

Let us be permitted, in conclusion, to repeat what we said at the beginning. A definition of this kind does not claim to explain the phenomena, but simply to summarize as many of them as possible. It will, we hope, soon be replaced by a more comprehensive definition that will include all the preceding facts and add still other phenomena, such as the physiological modifications that accompany this cerebral insufficiency. We only hope that this entirely provisional definition may now render some service and help clarify, to some extent, the countless observations long made by doctors and psychologists regarding the mental state of hysterical patients.